Washington State Department of Health

Facilities & Services Licensing
Construction Review Services
P.O. Box 47852
Olympia, Washington 98504-7852
Telephone: (360) 236-2944
Fax: (360) 236-2901
Internet: www.doh.wa.gov/crs

For Office Use Only			
Check No.	Amount	Facility ID No.	CRS Project No.

1 Project Information

Facility Name	Project Title			
Project **Site** Address	City	County	State WA	Zip

Type of Facility:

☐ Hospital	☐ Correctional Facility	☐ Boarding Home
☐ Nursing Home	☐ Alcohol Treatment Facility (ATF)	☐ Boarding Home w/Assisted Living Services (Chapter 388-110 WAC)
☐ Ambulatory Surgery Ctr. (ASC)	☐ Private Psychiatric Hospital	☐ Treatment Facilities For Psych. Impaired Children And Youth (PICY)
☐ Birthing Center	☐ Mobile Unit	☐ Adult Residential Rehabilitation Center (ARRC)
☐ Hospice Care Center	☐ Temporary Worker Housing	☐ Other _____

Building Permit Jurisdiction:	Building Construction Type:	Tax Parcel #:	Sprinkler System Type: ☐ 13 ☐ 13R ☐ 13D ☐ Other

Project Description:

☐ Interior Finish only ($80.00 fee) ☐ Small Project (completed checklist must be attached) ☐ Temporary Worker Housing (completed checklist must be attached) ☐ Change of Approved Use Only (completed work-no construction required)

2 Facility Info.

Owner / Facility Name	UBI #	Do you prefer to receive communications via: ☐ Email ☐ Postal Service ☐ Fax

Owner / Facility **Mailing** Address	City	State	Zip

Facility Telephone	Facility Fax

Facility Administrator ☐ Mr. ☐ Ms.	Telephone	Administrator's Email Address:
Facility Contact ☐ Mr. ☐ Ms.	Telephone	Facility Contact Email Address:

3 Consultant

Consultant (architect/engineer) Firm's Name	Do you prefer to receive communications via: ☐ Email ☐ Postal Service ☐ Fax

Consultant Firm's **Mailing** Address	City	State	Zip

Consultant's Telephone	Consultant's Fax

Consultant's Project Contact ☐ Mr. ☐ Ms	Consultant's Email Address

4 Project Cost

Project Cost Estimate: See WAC 246-314-010(4)

New Construction	
Alterations / Renovation	
Fixed Installed equipment	
Other costs including A/E fees	
Total of above	
Estimated date of occupancy	
Temporary Worker Housing ONLY (See WAC 246-359-990 Fees.)	

For Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Care Centers and Ambulatory Surgery Centers only.

Fill out portions below for projects that require Certificate of Need (**CON**) approval.

Current number of licensed beds.	
Number of licensed beds added in this project.	
Total proposed number licensed beds.	

Attach a copy of the Certificate of Need or Determination of Non-Reviewability. See Instructions on Back.

5

Signature	Title	Date

- **Include payment, two copies of the plans, and one copy of the functional program, with the completed application.**
- **Please make checks payable to Department of Health.**
- **Note: Incomplete applications will be returned without review.**

Instructions for Completing the Department of Health, Construction Review Services Application

(Subject to change without notice.)

Block 1 – Project information

- Fill in the facility name. The facility name should match the name given to the Department in previous applications, and should be the same as indicated on the facility license (if currently licensed).
- Enter the project title. The project title will identify the work to be performed, will remain the same throughout the project, and should be a limited number of characters. **All submissions shall be identified by the facility name and project title**.
- Enter the physical address of the location where the construction or renovation will occur.
- Check the most appropriate type of facility. A separate application and set of documents shall be submitted for projects containing multiple facility types. The documents should clearly identify which areas are to be included under which facility type.
- Construction Review Services (CRS) works closely with the local building jurisdiction. Please provide the name of the local building jurisdiction. In some cases there may be two local agencies that have jurisdiction. Please provide both jurisdictions.
- Enter a brief project description. For renovations, include the location within the facility where the renovation will occur (e.g., third floor, west wing, etc.).
- Interior Finish – The review fee for interior finish projects is $80. Projects that require no construction or physical modifications to the facility qualify as interior finish projects. Identical materials being installed to replace existing CRS approved materials, do not need to be submitted for review.
- Small Projects – **The Small Project checklist must be completed and submitted with the application**. The review fee schedule is listed on the checklist.
- Change of Approved Use – If this application is for a Change of Approved Use, the Construction Review fee will be $120. Change of use projects only apply to projects where construction is not required to meet the regulations for the intended use, and the facility is currently licensed by DOH/DSHS (e.g., patient room to office – submission of supporting documents still required).
- Temporary Worker Housing – **The Temporary Worker Housing Construction Standard checklist must be completed and submitted with the application**. The plan review fee schedule is listed on the checklist.

Block 2 – Facility information

- Enter the administrator name. This should be the same as indicated on the application for the facility license.
- Enter the email address, if available. To save time, CRS will often email review comments to the project team members.

Block 3 – Consultant

- The consultant is the architect or engineer that will be assisting you with your project. We strongly recommend the services of an architect or engineer be used as early in the project as possible. Licensing regulations require most facilities drawings to be stamped and signed by an architect or engineer registered in the state of Washington.

Block 4 – Project Cost.

- Review WAC 246-314-010(4) for the definition of project cost. Enter the estimated cost for new construction and alterations / renovations on the appropriate lines. Project cost shall include the cost of all project-related costs except taxes. Certain equipment costs may be waived from being included in the construction cost upon the approval of CRS. A request shall be made to CRS in writing before the approval can be granted. Enter the estimated date in which the space will be occupied for its intended use. For a project that requires Certificate of Need (CON) approval, fill in the appropriate information, for Hospitals, Psychiatric Hospitals, Hospice Care Centers, Ambulatory Surgery Centers, and Nursing Homes only. By signing this application, you attest that you have verified the applicability of CON, and the information provided is accurate.
- Review WAC 246-359-990 for Temporary Worker Housing fee schedule.

Block 5

- Sign and date the application. Include your title in relation to the project (i.e., Architect, Project Manager, Engineer, Administrator, etc.).
- The applicant acknowledges that upon presentation of identification, the Department may enter the building or premises to inspect or enforce provisions imposed by the applicable codes.

Block 6 – Temporary Worker Housing (TWH) Construction Standard **ONLY**

- In addition to submitting a completed CRS application (Blocks 1-5), all support approval documentation must be attached and submitted with the completed addendum page (Block 6).

ADDENDUM
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Temporary Worker Housing Site Approval Requirements for Plan Review

6 **Please note: ALL support approval documentation must be attached to this form**

Camp Location meets the requirements stated in WAC 246-359-150 ❑ Yes ❑ No

Water Supply

❑ City or Water District: Name:
Jurisdiction
Telephone:
Issue Date:

❑ Water System Name:
❑ Group A Jurisdiction
❑ Group B Telephone:
Issue Date:

Sewage Disposal

❑ City or Sewer District:

❑ Onsite Sewage

❑ Local Health Jurisdiction: ❑ State Jurisdiction: ❑ DOE Jurisdiction:

Name:
Telephone:
Issue Date:

Land Use (zoning and building requirements RCW 70.114A.50)

❑ Maximum Building
AHJ:
Name:
Telephone:

❑ Property Set Back Requirements:
Front:
Side:
Back:
AHJ:
Name:
Telephone

❑ Road Access Approval Date:
AHJ:
Name:
Telephone

❑ Exempt ❑ Non-Exempt

Electrical

❑ Approved for use by: Name:
L&I Staff:
Telephone
Issue

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